DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/28/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185430	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CLAIRE MEDICAL CENTER	222 MEDICAL CIRCLE MOREHEAD, KY 40351

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Recertification/Abbreviated Survey was conducted 09/14/10 through 09/16/10, and a Life Safety Code Survey was conducted 09/14/10. Deficiencies were cited with the highest Scope and Severity of a "F". ARO #15267 was substantiated with deficiencies cited.			
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated	F 225	F225 - Corrective Action taken at time of incident since retroactive chart. Once DON was notified on 8/23/10, a head to toe assessment of resident #4 was completed by Charge Nurse, to document current injuries. Investigation was initiated immediately. MD, Administrator, OIG and DCBS were notified 8/23/10. Don and Administrator reviewed current abuse policy and investigation forms for compliance with F225 and determined it was compliant. DON conducted Mandatory facility Staff training on 8/24/10 to review entire abuse policy and reporting requirements. A quiz was used to demonstrate knowledge retention. The RN that first saw the injury on this resident 8/22 but did not report it correctly, was counselled on 8/25/10.	10/27/10

RECEIVED
OCT 26 2010
BY:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE resubmitted

Administrator 10/26/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	Continued From page 1 representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to have an effective system to ensure all alleged violations involving abuse or injuries of unknown source were reported immediately to the Administrator of the facility and to State Agencies in accordance with state law for one (1) of four (4) sampled residents (Resident #4). The findings include: Review of the facility's policy entitled "Abuse, Neglect, Involuntary Seclusion and Misappropriation of Property", dated 10/09 revealed "all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to immediate supervisor, Nurse Manager, and /or Administrator. The Administrator or his/ her designee notifies the OIG division of Long Term Care; and the local Adult Protection Services, the local Ombudsman and if appropriate the local or State police, of any alleged violation". Review of Resident #4's closed medical record revealed diagnoses which included End Stage Renal Disease (ESRD), Chronic Renal Failure, Bladder Cancer, and Sepsis of Urinary Origin.	F 225	New posters stating reporting requirement and time lines were placed in staff lounge, conference room, and locker rooms 9/29/10. All other residents were given a complete head to toe assessment on 8/23/10 by DON and Charge Nurse, to assess for unknown injuries. None were found. Administrator and DON reviewed investigation process and forms reported 8/23/10 and found it to be in compliance apart from the "immediate reporting" by nurse when injury was found. Administrator and Director of HR reviewed current policy that states that persons found guilty of abuse/neglect/mistreatment of residents in a court of law are not hired to work in the facility. This was verified by HR Director and current employee files were checked for evidence of criminal background checks and checked against abuse registry again and found to be in compliance.	

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F 225	Continued From page 2 Review of the Admission Minimum Data Set (MDS) Assessment dated 08/21/10 revealed the facility assessed the resident as having no impairment in cognitive skills and as receiving dialysis. Review of the Plan of Care dated 08/10 revealed the resident was at risk for injury related to receiving heparin (anti-coagulant medication) and should be observed for unusual signs and symptoms of bleeding. Review of the facility's Investigation entitled "Resident Abuse Report Form" revealed an investigation was completed related to the resident's bruises and a fracture. The investigation stated Resident #4 left for dialysis and upon return to the facility, the nurse noted the resident to have increased confusion and complained of back and shoulder pain and the nurse noted bruising to the shoulder and was unsure if it was from the dialysis visit. The investigation further stated, on 08/22/210 the nurse noted the bruise to be worsening and the resident complained of discomfort. Continued review of the investigation, revealed the Physician was notified and an x-ray was done of the right shoulder which denoted a Right Acromion Fracture. Further review of the investigation revealed the Administrator was notified on 08/23/10 at 10:00 AM, the Office of Inspector General was notified on 08/23/20 at 3:00 PM and the Department of Community Based Services was notified on 08/23/210 at 1:00 PM. Review of the Nurse's Notes dated 08/21/10 at 7:00 AM revealed the resident had "gone to dialysis". Review of an entry dated 08/21/10 at 11:10 AM revealed upon return from dialysis the	F 225	Monitoring Process: Facility Administrator and DON receive abuse registry reports from the state and review for any employee names. Mock Abuse Reporting will be performed 10/26/10 to evaluate staff response on all shifts. Any shifts/persons failing this Mock investigation will be retested until they pass correctly. This will also be performed annually by DON/ Administrator. QA Committee will continue to review all incident reports quarterly, and ensure appropriate and timely actions are taken per policy. Any aberrances will be addressed and staff training will occur. HR Director will continue to monitor abuse and criminal background checks on all new employees on an ongoing basis.	

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F 225	Continued From page 3 patient was alert and seemed very confused. Further review of the Notes revealed safety precautions were in place, due to confusion. An entry at 12:50 PM revealed the resident complained of back and shoulder pain and medication was administered. Review of the Nurses' Notes dated 08/21/10 (wrong date-should be 8/22/10 per interview with the Director of Nursing on 09/16/10 at 8:30 AM) at 8:00 AM revealed there was a large bruise noted to the resident's right shoulder and the resident complained of right shoulder pain. "Son stated he hurt it yesterday while at dialysis". An entry at 10:00 AM revealed new Physician's Orders were received. An entry at 1:00 PM revealed the resident was off the floor for an X-Ray. An entry at 3:30 PM revealed an Orthopedic consult was ordered due to a fracture of the Acromion. Interview on 08/15/10 with Licensed Practical Nurse (LPN) #4 revealed she was assigned to the resident on 08/21/10, when the resident returned from dialysis. She further stated the residents' son brought the resident back from dialysis and stated he had stepped on the resident's catheter and almost dropped the resident while transferring the resident into the car. LPN #4 stated she assessed the resident and noticed bruising on the resident's abdomen and right shoulder. Further interview revealed the bruising on the resident's right shoulder was light purple in color and was a little larger than a half dollar. LPN #4 stated she reviewed the chart and noted there was documentation of the resident having multiple bruising on the trunk and over the residents body. She further stated the resident complained of pain and hurting all over and she administered pain medication. Continued	F 225	Abuse policy will remain on the monthly Facility Staff Meeting agenda as a regular item to be reviewed with no end date.	

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F 225	Continued From page 4 interview, revealed she did not notify the Physician or Administration of the bruising or pain because after review of the medical chart, the resident already had bruising and the pain was not new. Interview on 09/16/10 at 3:00 PM with Registered Nurse (RN) #3 revealed she was assigned to the resident on 08/22/10 which was the day after the resident had been to dialysis. She stated she noted a bruise on the resident's back and a dark purplish raised bruise which was five (5) to six (6) inches across on the resident's right shoulder. She stated the resident was unable to explain where the bruises came from; however, the son stated the resident fell at dialysis. Further interview, revealed she notified the Physician and an X-Ray was ordered which revealed a fracture. She stated the bruises and fracture were injuries of unknown source; however, she did not think about the injury being possible abuse. Continued interview revealed she had abuse training; however did not notify her supervisor or administration. During an interview with the DON, on 09/16/10 at 8:30 AM, she revealed the bruising and fracture were not reported to her until 08/23/10. The DON indicated she had "preached" to the nurses in reference to Administration needing to be notified immediately if there was an injury of unknown source. She stated the "ball was dropped" and Administration, and the state agencies should have been notified on 08/22/10 of the resident's injury of unknown source. Interview on 09/16/10 at 10:30 AM with the Administrator revealed she was not notified of the residents bruising and fracture until 08/23/10 and	F 225		

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F 225	Continued From page 5 she should have been notified "right away".	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to implement their Abuse Policy and Procedures regarding reporting injuries of unknown source immediately to the Administrator of the facility and to State Agencies in accordance with state law for one (1) of four (4) sampled residents (Resident #4). The findings include: Review of the facility's policy entitled "Abuse, Neglect, Involuntary Seclusion and Misappropriation of Property", dated 10/09 revealed "all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to immediate supervisor, Nurse Manager, and /or Administrator. The Administrator or his/ her designee notifies the OIG division of Long Term Care, and the local Adult Protection Services, the local Ombudsman and if appropriate the local or State police, of any alleged violation". Review of Resident #4's closed clinical record revealed diagnoses which included End Stage Renal Disease (ESRD), Chronic Renal Failure,	F 226	F226 - Corrective Action taken at time of incident since retroactive chart. Once DON was notified on 8/23/10, a head to toe assessment of resident #4 was completed by Charge Nurse, to document current injuries. Investigation was initiated immediately. MD, Administrator, OIG and DCBS were notified 8/23/10. Don and Administrator reviewed current abuse policy and investigation forms for compliance with F226 and determined it was compliant. DON conducted Mandatory facility Staff training on 8/24/10 to review entire abuse policy and reporting requirements. A quiz was used to demonstrate knowledge retention. The RN that first saw the injury on this resident 8/22 but did not report it correctly, was counselled on 8/25/10.	10/27/10

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F 226	Continued From page 6 Bladder Cancer, and Sepsis of Urinary Origin. Review of the facility's investigation entitled "Resident Abuse Report Form" revealed an investigation was completed related to bruises and a fracture. The investigation revealed the resident left for dialysis at approximately 6:30 AM on 08/21/10 and was transported by the resident's son's personal vehicle. The resident's son picked up the resident at the dialysis clinic at approximately 11:15 AM and transported the resident back to the facility. The nurse noted the resident to have increased confusion upon return to the facility. Further review of the investigation revealed the dialysis clinic called to report the resident had been agitated and confused while at the clinic. The resident complained of back and shoulder pain and the nurse noted there was bruising to the shoulder and was unsure if it was from the the dialysis visit. The nurse on 08/22/10 noted the bruise to be worsening and the resident complained of discomfort. According to the investigation, the Physician was notified and an x-ray was done of the right shoulder which denoted a Right Acromion Fracture. Further review of the investigation revealed the Administrator was notified on 08/23/10 at 10:00 AM. Review of the Nurses' Notes dated 08/21/10 (Per DON, on 09/16/10 at 8:30 AM, incorrect date, date should be 8/22/10) at 8:00 AM revealed there was a large bruise noted to the resident's right shoulder and the resident complained of right shoulder pain. "Son stated he hurt it yesterday while at dialysis". An entry in the Nurse's Notes at 10:00 AM revealed new Physician's Orders were received. An entry in the Nurse's Notes at 1:00 PM revealed the resident	F 226	New posters stating reporting requirement and time lines were placed in staff lounge, conference room, and locker rooms 9/29/10. All other residents were given a complete head to toe assessment on 8/23/10 by DON and Charge Nurse, to assess for unknown injuries. None were found. Administrator and DON reviewed investigation process and forms reported 8/23/10 and found it to be in compliance apart from the "immediate reporting" by nurse when injury was found. Administrator and Director of HR reviewed current policy that states that persons found guilty of abuse/neglect/mistreatment of residents in a court of law, are not hired to work in the facility. This was verified by HR Director and current employee files were checked for evidence of criminal background checks and checked against abuse registry again and found to be in compliance.	

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F 226	Continued From page 7 was off the floor for an X-Ray. Further review of the Nurses' Notes revealed an entry at 3:30 PM, which stated an Orthopedic Consult was ordered due to a Fracture of the Acromion. Interview on 09/15/10 at 3:00 PM with Registered Nurse (RN) #3 revealed she was assigned to the resident on 08/22/10 and she noticed a bruise on the resident's back and a dark purplish raised bruise which was five (5) to six (6) inches across on the resident's right shoulder. She stated the resident was unable to explain where the bruises came from. She further stated the resident's son told her the resident fell at dialysis. Further interview, revealed she notified the Physician and an x-ray was ordered which revealed a fracture. She stated the bruises and fracture were injuries of unknown source; however, she did not think about the injury being possible abuse. Continued interview revealed she had abuse training; however did not notify her supervisor or administration. Interview on 09/16/10 at 8:30 AM with the Director of Nursing (DON) revealed RN# 3 worked 8/22/10 and noticed the large bruising on the resident's shoulder and notified the Physician. However, she further stated the bruising and fracture were not reported to her or Administration until 08/23/10. Continued interview revealed she had "preached" to the nurses in reference to Administration needing to be notified immediately if there was an injury of unknown source. She further stated the "ball was dropped" and Administration, and the state agencies should have been notified on 08/22/10 of the resident's injury of unknown source. Interview on 09/16/10 at 10:30 AM with the	F 226	Monitoring Process: Facility Administrator and DON receive abuse registry reports from the state and review for any employee names. Mock Abuse Reporting will be performed 10/26/10 to evaluate staff response on all shifts. Any shifts/persons failing this Mock investigation will be retested until they pass correctly. This will also be performed annually by DON/ Administrator. QA Committee will continue to review all incident reports quarterly, and ensure appropriate and timely actions are taken per policy. Any aberrances will be addressed and staff training will occur. HR Director will continue to monitor abuse and criminal background checks on all new employees on an ongoing basis. Abuse policy will remain on the monthly Facility Staff Meeting agenda as a regular item to be reviewed with no end date.	

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F 226	Continued From page 8 Administrator revealed she was notified of the residents bruising and fracture on 08/23/10; however she should have been notified "right away".	F 226		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to develop a Comprehensive Plan of Care based on the resident's Comprehensive Assessment which included measurable objectives and individualized interventions to meet the resident's needs for one (1) of four (4) sampled residents (Resident #4).	F 279	No corrective action was possible for the closed chart of resident #4. All current resident's Comprehensive Care Plans were reviewed for accuracy and completeness on 9/17/10 by DON and MDS Coordinator. None were found to be deficient. New measures implemented - Floor nurse will continue to initiate admission care plan, using a care plan check list tool. The tool will trigger required care plans. The tool will be given to MDS Coordinator to review for accuracy and completeness. Comprehensive care plan will now be developed by the MDS Coordinator instead of floor nurse. MDS Coordinator will receive a copy of each Physician order written and will be responsible for updating care plan.	10/6/2010

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F 279	Continued From page 9 The findings include: Review of the facility "Comprehensive Care Plans" Policy revealed each resident "shall" have a comprehensive care plan which included measurable objectives and timetables to meet the resident's medical, nursing and psychosocial which were identified in the comprehensive assessment. Review of Resident #4's closed record revealed diagnoses which included End Stage Renal Disease (ESRD), Chronic Renal Failure, Bladder Cancer, and Sepsis of Urinary Origin. Review of the Admission Minimum Data Set (MDS) Assessment dated 08/21/10 revealed the facility assessed the resident as having no short or long term memory loss and as requiring limited to extensive assistance with Activities of Daily Living. Further review of the MDS revealed the facility assessed the resident as receiving dialysis. Review of the Resident Assessment Protocol Summary (RAPS) dated 08/21/10 revealed the resident was admitted to the facility with Debility and other chronic medical comorbidities and was receiving dialysis. Review of the Admission Physician's Orders dated 08/09/10 revealed the resident had a Right Udall catheter with Orders for dialysis Tuesdays, Thursdays and Saturdays. Review of the Nursing Assessment Flowsheets dated 08/09/10 through 08/25/10 revealed a section labeled "IV therapy"which stated the resident had a Udall catheter.	F 279	Random care plan audits will be done on 2 charts a week by DON or Administrator.	

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F 279	Continued From page 10 Review of the Comprehensive Plan of Care revealed a problem of ineffective tissue perfusion related to Renal Failure. The goal stated the resident would have adequate tissue perfusion as evidenced by no edema, hypertension and/pr changes in laboratory data. There were several approaches included; however, the Plan of Care did not address the potential for infection related to the Udall catheter and did not specify the resident was attending dialysis three times per week. Interview on 09/16/10 at 8:30 AM with the Director of Nursing (DON) revealed neither the Plan of Care nor the Kardex which the nurses updated daily addressed the Udall catheter which was used for dialysis. The DON stated the catheter should have been addressed on the Plan of Care related to the risk for infection. The DON indicated the plan should have included an intervention regarding the resident going to dialysis three times per week. Interview on 09/16/10 at 12:00 PM with the MDS Coordinator revealed the staff nurses were responsible for developing the Plans of Care. She stated she completed the MDS and the Resident Assessment Protocols (RAPS) and gave the staff nurses a copy which included the areas which needed to be care planned. She stated each resident had a Care Plan Meeting on each Tuesday and the Plans of Care were reviewed. She stated she updated and revised the Plans of Care after the meetings when she noted there was an area that needed to be addressed. She further stated Resident #4 should have had a Plan of Care developed related to the risk of infection with a Udall catheter and she was unsure why it was missed.	F 279		

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F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure the Plan of Care was sufficient to meet the needs of newly admitted residents for two (2) of four (4) sampled residents (Resident #2 and #3). The findings include: Review of the facility Comprehensive Care Plans Policy, revealed "there shall be regularly scheduled meetings that initiate all newly admitted residents nursing care plans and to systematically maintain designated updates on in-house residents, have all appropriate disciplines in attendance". 1. Review of Resident #2's medical record revealed the resident was admitted to the facility from the hospital on 09/10/10 with diagnoses which included Left Acute Cerebral Vascular Accident. Further record review revealed the Admission Minimum Data Set (MDS) Assessment had not been completed due to the recent admission. Observation of the resident on 09/14/10 at 12:00 PM, 2:30 PM and 3:30 PM, revealed the resident had intravenous fluids infusing of D5 1/2 Normal Saline with 20 K+ (5% Dextrose Normal Saline with twenty milliquivalents of Potassium) at 110 ml	F 281	Resident #2 - plan of care was updated by DON 9/17/10 to include IV fluids, IV site care, and anticoagulant therapy. Resident #3 - plan of care updated by DON 9/17/10 to include anticoagulant therapy. All other resident's care plans were reviewed by DON and MDS Coordinator for accuracy and updated as necessary. New measures implemented: Floor nurse will continue to initiate admission care plan using a care plan check list tool. The tool will trigger required care plans. The tool will be given to MDS Coordinator to review for accuracy and completeness. Comprehensive care plan will now be developed by the MDS Coordinator instead of the floor nurse. MDS Coordinator will receive copy of each physician order written and will be responsible for updating care plan.	10/6/2010

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F 281	Continued From page 12 (one hundred and ten milliliters) per hour. Further observation revealed the intravenous (IV) site was in the left forearm. Review of the Admission Physician's Orders dated 09/10/10 at 9:15 AM revealed orders for intravenous fluids of D51/2 NS at 110 ml /hr (5%Dextrose Normal Saline at one hundred and ten milliliters per hour). Further review of the Physician's Orders dated 09/11/10 at 7:30 AM revealed orders for four (4) runs of ten (10) milliquivalents (meq) potassium intravenous (IV), and forty (40) meq PO (by mouth) liquid K+ (potassium) now and a repeat (Basic Metabolic Panel) BMP at 10:00 AM. Physician's Orders dated 9/11/10 at 4:10 PM revealed orders for NS (Normal Saline) at 110 ml's per hour and a BMP in the AM. Review of the Physician's Orders dated 09/12/10 at 5:35 AM revealed orders for NS +20 K at 110 cc/ hr and four runs of 10 meq potassium IV. Physician's Orders dated 09/12/10 at 6:05 AM revealed orders to change to D51/2 NS +20 K+ at 110 ml/ hr. Review of the Interim Plan of Care revealed there was no Plan of Care to address the resident's intravenous fluids or the need to monitor the resident for dehydration or fluid overload related to the IV fluids. Also, there was no Plan of Care to address monitoring the IV site for signs and symptoms of infection or infiltration. Further review of the Admission Physician's Orders dated 09/10/10 revealed orders for Aggrenox 25-200 milligrams (anti-platelet medication) twice daily at mealtime and Heparin Injection 5,000 units SQ (subcutaneous) (anti-coagulant medication) every eight (8) hours. Further review	F 281	Random care plan audits will be done by DON and/or Administrator (2 charts a week)	

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F 281	Continued From page 13 of the Physician's Orders dated 09/14/10 revealed Orders to discontinue Aggrenox and start Plavix 75 milligrams (anti-platelet agent). Review of the Plan of Care revealed the anticoagulants/antiplatelets and complications and risk factors associated with the medications were not addressed. Interview on 09/16/10 at 10:20 AM with Registered Nurse (RN) #1 revealed she had completed the Interim Plan of Care for Resident #2 on the day the resident was admitted. She stated she was not assigned to the resident on the day of admission; however, she was assisting the admitting nurse. Further interview revealed at times the Physician's Orders were not available when the Plans of Care were completed and this may have been the reason she had not addressed the intravenous fluids, and the antiplatelet/anticoagulant medications on the Care Plan. She further stated, every nurse assigned to the resident was responsible for updating the Plan of Care. Continued interview revealed the resident should have had Plans of Care related to the intravenous fluids and the risk of infection/infiltration at the IV site. She further stated the Plan of Care should have addressed the antiplatelet/ anticoagulant medication due to the risk of abnormal bleeding. Interview with the Director of Nursing on 09/15/10 at 9:15 AM revealed the Admission nurse was to complete the Initial Plan of Care and the Plan of Care was to be revised by the nurses with Physician's Orders. She further stated the team had a Care Plan meeting for each resident in the facility on Tuesdays and reviewed and revised the Plans of Care at that time. She stated the	F 281		

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F 281	Continued From page 14 resident should have had Plans of Care related to the risks involved with intravenous fluids, the IV site, and the anti-platelet/ anticoagulant medications. 2. Resident #3 was admitted on 09/09/10 with diagnoses which included Right Intracerebral Hemorrhage, Hypotension and Hyperlipidemia. Review of Resident #3's Physician orders revealed order for Heparin five thousand units (5,000) subcutaneous (SQ) twice a day (BID) prophylactically for prevention of Deep Vein Thrombosis (DVT). Review of the Plan of Care Plan developed upon Resident #3's admission revealed the care plan failed to address the resident was receiving anticoagulation therapy. Therefore, no interventions were in place to guide staff related to Resident #3's needs regarding anticoagulation therapy. Interview with License Practical Nurse (LPN) #1 on 09/16/10 at 9:15 AM revealed Heparin SQ prophylactically for DVT does not require routine lab work. Anticoagulation lab work is managed by the physicians office. Interview with Registered Nurse RN #1 09/16/10 at 8:45 AM revealed a care plan is initiated when a resident is admitted to the unit based on the residents condition, history, diagnosis and medication. Further interview with RN #1 revealed it is not uncommon for the nurse not to see the medication list for several hours following admission and a care plan for medication to get overlooked.	F 281		

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F 281	Continued From page 15 Further interview with RN #1 revealed a care plan related to anticoagulation therapy was overlooked for Resident #3.	F 281		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure an indwelling catheter was not used unless there was valid justification for one (1) of four (4) sampled residents (Resident #2). The findings include: Review of Resident #2's medical record revealed the resident was admitted to the facility from the hospital on 09/10/10, with diagnoses which included Left Acute Cerebral Vascular Accident. Further record review revealed the Admission Minimum Data Set (MDS) Assessment had not been completed due to the recent admission. Observation of the resident on 09/15/10 at 8:40 AM revealed the resident was in the bed and urinary drainage tubing was noted to be draining	F 315	Resident #2 - resident's medical history was reviewed for need of indwelling catheter on 9/17/10. MD was called and discussion for need took place. It was determined that catheter should be removed. Catheter removed same day 9/17/10. Current residents with indwelling catheters were reviewed and assessed for need by DON and Charge Nurse on 9/17/10. Actions taken as appropriate. Measures implemented: 1. Urinary Incontinence assessment tool will be done by admitting nurse, on all new residents. Tool will identify and determine type of urinary incontinence, bladder function, and risk for UTI and will trigger for specific care plan interventions.	10/25/10

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F 315	Continued From page 16 yellow urine into the urinary drainage bag. Review of the Admission Physician's Orders dated 09/10/10 revealed Orders for a Foley Cathter every shift and as needed (prn). Review of the Interim Plan of Care revealed the resident had impaired urinary elimination related to the use of a Foley catheter. The interventions included observing for signs and symptoms of a Urinary Tract Infection. Further record review revealed there was no evidence of a diagnoses for the use of an indwelling catheter Interview with the Director of Nursing (DON) on 09/15/10 at 9:15 AM revealed she was unsure why the resident had a Foley catheter and she would review the record. Further interview with the DON on 09/16/10 at 9:00 AM and 11:00 AM revealed there were guidelines the facility referred to in order to evaluate the need for continuing a Foley catheter, and after record review the resident's medical condition did not fit the guidelines. She further stated the resident's indwelling catheter should have been removed after admission to the facility due to there was no diagnoses or justification for the catheter. The DON revealed the Activities Director who was also a Certified Nursing Assistant (CNA) completed audits to ensure Foley catheters were removed on new admits from the hospital if there was no medical justification for the catheter. She stated the CNA was on vacation which was probably why Resident #2's Foley Catheter "had been missed".	F 315	2. For residents admitted with an indwelling catheter there is now a standing order that allows facility to discontinue catheter that does not meet LTC regulations (listed on standing order) 3. Current catheter audit tool that is completed on admission by MDS Coordinator, will now have sections which will include: a) checking for presence of a completed urinary assessment tool and appropriate care plan b) to determine if diagnosis and condition warrants continued indwelling catheter use c) to check for presence of physician's order. d) to address risks for infection e) need for Urology consult Areas identified as deficient will be addressed and corrected immediately by MDS Coordinator.	

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F 315	Continued From page 17 Review of the facility's "Diagnostic Guidelines for anchoring/ maintaining Foley Catheter" included; Retention which could not be controlled by in and out caths and included a Physician's diagnosis, documented post void residual of greater than two hundred (200) milliliters, contamination of a Stage III or Stage IV wound where incontinence of urine could impede the healing process, or terminal illness or severe impairment which would make positioning or clothes change uncomfortable or painful for the resident. The Guidelines further stated there should be a discussion with the Physician on the reason for a Foley and a diagnosis or specific reason should be documented for the Foley. Continued review of the Guidelines revealed Foley Catheters needed to be discontinued within 24 hours of admission unless the catheter falls under the above criteria for placement or specific Physician documentation supports it.	F 315	All catheter audits are reviewed at quarterly QA committee. Identified issues will be addressed and actions will be taken as appropriate.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, and interview it was determined the facility failed to ensure food was	F 371	Immediately, kitchen area was checked by Director of food services for compliance with this regulation. Any edible items found to be not in compliance were disposed of immediately. Any equipment found to be not in compliance was cleaned, re-santitized, and stored per regulation immediately. The flour scoop holder was replaced so that the scoop would be inside the bin and covered	10/5/10

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F 371	Continued From page 18 stored, prepared, and distributed under sanitary conditions. The findings include: Observation of the kitchen during the initial tour on 09/14/10 at 10:00 AM revealed the walk in refrigerator contained a bag of donuts, a bag of chopped green peppers, and two (2) bags of chopped carrots which had been opened and were not labeled as to food item or date opened. In addition, a bottle of ketchup and a gallon container of salad dressing had been opened and were not labeled with an open date. Observation of the salad walk in refrigerator revealed a container of grated cheese and a container of parmesan cheese which had been opened and were not labeled with an open date. Observation of the refrigerator revealed two strawberry pies and two cherry pies which were uncovered. Observation of the dry storage area revealed spices which were not labeled with the open date including salt, sesame seeds, paprika, rubbed sage, bay leaves, black pepper, seasoning salt, red crushed pepper, poultry seasoning, hamburger seasoning, and red crushed pepper. Further observation revealed the flour scoop had been left on top of the flour bin. Interview with the Kitchen Supervisor, during the tour, revealed all items in the refrigerators were to be labeled as to contents and as to open date, and the pies should have been covered, labeled and dated. She further stated the cooks were .	F 371	A mandatory in-service was conducted by Food Services Director for all shifts on 9/17/10 and 9/18/10. Staff reviewed policy re storage, preparation, distribution and serving of food under sanitary conditions per regulation. Deficiencies found during the survey were reviewed and discussed. Systemic changes: 1.The shift supervisor will be responsible for completing all food safety and dietary sanitation audits each shift. Any issues are corrected immediately. The Food Production Manager reviews audits and corrections weekly and reports to Director Food Services. 2.During the current biweekly Inventory Process in the kitchen, another step was added where all products will be checked for appropriate labeling.	10/5/10

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F 371	Continued From page 19 responsible for checking the refrigerators two times a day to ensure this was done and to throw away any food item which was not labeled and dated. The Kitchen Supervisor revealed "75% of the spices had not been labeled when opened". She further stated the spices were to be labeled with an open date and she had told the kitchen staff multiple times to ensure this was done. She further stated spices were good for six (6) months to a year after opening, and after a year the spices would lose their flavor. Continued Interview revealed the Scoop holder had broken off the flour bin. She stated the scoop should not have been placed on top of the flour bin, and should have been removed and washed after use. Interview on 09/14/10 at 5:00 PM with the Cook revealed he worked 6:00 AM to 2:30 PM and he checked the refrigerators at the end of his shift. He further stated if any food items were unlabeled, undated or expired, he would throw them away, at that time. Further interview revealed he was ill the prior day and was not at the facility to check the refrigerators; however, the second shift cook was also responsible for checking the refrigerators at the end of the second shift.	F 371	Kitchen remodelling also began 10/25/10 which will allow for more storage space and refridgerator space. This will improve our ability to store, prepare, distribute and serve food per regulation. Monitoring process: 1. Food Production Manager checks q-shift audits and reports issues to Director Food Svcs. 2. Biweekly inventory audit 3. Dietary sanitation is now a fixed item for discussion at each monthly staff meeting 4. Audits will be submitted to quarterly QA committee for review and discussion.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control	F 441	Immediate corrective action; RN #1 immediately went to her supervisor when the surveyors pointed out her error. The glucometer was wiped down and set back in the cradle before any resident was affected.	10/28/10

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F 441	Continued From page 20 Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure there was an effective infection control program in place to provide a safe and sanitary environment to help prevent the development and transmission of disease and infection. The findings include:	F 441	All nursing staff on the floor at the time were in-serviced by DON, on process of disinfecting glucometer between residents. A mandatory in-service for glucometer disinfecting for all nursing staff occurred on 9/21/10 and 9/22/10 for all shifts by DON. A bright sticker was placed on the glucometer to remind staff to disinfect between residents. It was determined no other residents were affected by policy non-compliance by: 1. Charge Nurse continued to monitor existing residents for signs of infection i.e. temperature spikes. 2.9/17/10 - administrator conducted "on the spot" audits to ensure staff were following infection control policy practices. Staff were corrected and re-educated as necessary.	

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F 441	Continued From page 21 Observation on 09/14/10 at 11:10 AM revealed Registered Nurse (RN) #1 wash her hands, gather supplies, put on gown and gloves to provide care for a resident who was diagnosed with Methicillin Resistant Staphylococcus Aureus (MRSA). RN #1 was observed to perform an Accucheck on the resident, document the results and then removed her protective equipment (PPE). The RN then washed her hands and carried the Glucometer, without donning gloves and placed the Glucometer into the charging base. Interview with RN #1 revealed the normal procedure was to sanitize the Glucometer with PDI Super Sani-Cloth, which was a germicidal, bacteriocidal, tuberculocidal and virucidal sanitizing wipe approved by the Glucometer manufacturer. Further interview revealed she should have sanitized the Glucometer before replacing it on the base. RN #1 stated staff received glucometer training annually. Review of the facility's Glucometer Policy dated 02/19/09 and Procedure number 12-0110-10, revealed the Glucometer needed to be cleaned with a disinfectant prior to replacing the Glucometer on the charge base. Review of the Manufacturers maintenance and handling information revealed the acceptable disinfectant and/or cleaner for the Glucometer were soap and water, 70% (or less) isopropyl alcohol or a 1:10 dilution of sodium hypochlorite ammonium compounds.	F 441	Administrator and DON reviewed facility infection control policy to ensure compliance with LTC regulations. It was determined to be compliant on 10/25/10. Mandatory facility staff training on entire infection control policy to be done 10/27/10. Quiz on infection control policy will be given at end of in-service. Monitoring: 1. Pharmacy residents have added "monitoring glucometer disinfection" to their quarterly med-pass compliance observations. Compliance issues will be reported to QA committee and addressed 2. Administrator to continue "on the spot" infection control compliance checks one day a month. 3. All facility infections will continue to be tracked and trended and reported to quarterly QA Committee where they are addressed. 4. Infection Control Committee also requires a monthly hand-washing and universal precautions/PPE audit be conducted and submitted by a facility clinician.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185430	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/14/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and concluded on 09/14/2010. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest scope and severity deficiency identified was a " F ".	K 000	RECEIVED OCT 05 2010 BY:_____	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the emergency generator had an annunciator panel according to NFPA codes. The findings include: Observation on 09/14/2010 at 1:00 PM, revealed the emergency generator annunciator panel was located at in the switchboard office. The observation was confirmed with the Maintenance Supervisor. Interview on 09/14/2010 at 1:00 PM, with the Maintenance Supervisor, revealed the Switchboard Office was not occupied between the hours of 11:30 PM and 6:00 AM.	K 144	As of 10/4/10 quotes for a new annunciator or to move the annunciator from the switchboard to the ER registration, are in progress. A visible and audible annunciator (connected to emergency generator) will be located in the ER registration area which is staffed 24hrs a day and 7 days a week. Until new annunciator is placed, a check of the annunciator in the switchboard area will be added to the rounds of the security team each hour between 11.30pm and 6am.	10/30/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 144	Continued From page 1 Reference: NFPA 99 (1999 Edition). 3-4.1.1.15 + Alarm Annunciator. A remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see NFPA 70, National Electrical Code, Section 700-12.) The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: (a) Individual visual signals shall indicate the following: 1. When the emergency or auxiliary power source is operating to supply power to load 2. When the battery charger is malfunctioning (b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following: 1. Low lubricating oil pressure 2. Low water temperature (below those required in 3-4.1.1.9) 3. Excessive water temperature 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply 5. Overcrank (failed to start) 6. Overspeed Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur, but need not display these conditions individually. [110: 3-5.5.2]	K 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: M Hollifield — TITLE: Administrator — (X6) DATE: 10/5/10

* deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.